



## STATE OF ILLINOIS

Page 2

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,490</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>18,980</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>78</u>	TOTALS	<u>78</u>	<u>28,470</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,990</u>	<u>919</u>	<u>1,097</u>	<u>4,006</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>13,198</u>	<u>1,828</u>	<u>0</u>	<u>15,026</u>	10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>15,188</u>	<u>2,747</u>	<u>1,097</u>	<u>19,032</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.85%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A - None

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/7/1998 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 26 and days of care provided 1,097Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

## IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number SCOTCHWOOD HEALTH CARE CENTER

# 0043661

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	122,883	6,261	6,210	135,354		135,354		135,354			1
2	Food Purchase		83,737		83,737		83,737	(2,404)	81,333			2
3	Housekeeping	75,875	5,355	619	81,849		81,849		81,849			3
4	Laundry	23,203	4,771		27,974		27,974		27,974			4
5	Heat and Other Utilities			58,437	58,437		58,437	222	58,659			5
6	Maintenance	33,475	8,699	30,133	72,307		72,307	9,879	82,186			6
7	Other (specify):*			5,177	5,177		5,177		5,177			7
8	<b>TOTAL General Services</b>	255,436	108,823	100,576	464,835		464,835	7,697	472,532			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	872,020	72,579	28,170	972,769		972,769		972,769			10
10a	Therapy	16,295	13,042	107,041	136,378		136,378		136,378			10a
11	Activities	50,093	1,731	2,712	54,536		54,536		54,536			11
12	Social Services	52,141		2,712	54,853		54,853		54,853			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	990,549	87,352	140,635	1,218,536		1,218,536		1,218,536			16
	<b>C. General Administration</b>											
17	Administrative	64,023		2,733	66,756		66,756	1,128	67,884			17
18	Directors Fees											18
19	Professional Services			11,484	11,484		11,484	21,197	32,681			19
20	Dues, Fees, Subscriptions & Promotions			16,810	16,810		16,810	140	16,950			20
21	Clerical & General Office Expenses	67,231	21,900	128,893	218,024		218,024	35,160	253,184			21
22	Employee Benefits & Payroll Taxes			202,562	202,562		202,562	5,468	208,030			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,770	11,770		11,770	497	12,267			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,611	63,611		63,611		63,611			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	131,254	21,900	437,863	591,017		591,017	63,590	654,607			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,377,239	218,075	679,074	2,274,388		2,274,388	71,287	2,345,675			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number **SCOTCHWOOD HEALTH CARE CENTER** #0043661 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			49,852	49,852		49,852	(2,338)	47,514			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			287,434	287,434		287,434	(5,018)	282,416			32
33	Real Estate Taxes			21,413	21,413		21,413		21,413			33
34	Rent-Facility & Grounds			1,651	1,651		1,651	2,767	4,418			34
35	Rent-Equipment & Vehicles			51,273	51,273		51,273	222	51,495			35
36	Other (specify):*							154	154			36
37	<b>TOTAL Ownership</b>			411,623	411,623		411,623	(4,213)	407,410			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			532	532		532		532			38
39	Ancillary Service Centers		23,702	966	24,668		24,668		24,668			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,705	42,705		42,705		42,705			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		23,702	44,203	67,905		67,905		67,905			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,377,239	241,777	1,134,900	2,753,916		2,753,916	67,074	2,820,990			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number SCOTCHWOOD HEALTH CARE CENTER

# 0043661

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,237)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(20)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(167)	2		13
14	Non-Care Related Interest	(6,017)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,087)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(486)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See page 5a)	(3,316)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,330)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	81,404	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 81,404		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 67,074		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS  
SCOTCHWOOD HEALTH CARE CENTER

Page 5A

ID# 0043661  
Report Period Beginning: 1/1/2002  
Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4	Non-Patient Meals	(2,237)	2	4
5				5
6				6
7				7
8				8
9				9
10	Interest and Other Investment Income	(20)	32	10
11				11
12				12
13	Sales Tax	(167)	2	13
14	Non-Care Related Interest	(6,017)	32	14
15				15
16				16
17				17
18	Fines and Penalties	(2,087)	21	18
19				19
20				20
21				21
22	Special Legal Fees & Legal Retainers	(486)	19	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31	Other non allowable expense	(3,316)	30	31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,330)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SCOTCHWOOD HEALTH CARE CENTER

# 0043661

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,404)	0	0	0	0	0	0	0	0	0	0	(2,404)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	222	0	0	0	0	0	0	0	0	0	222	5
6	Maintenance	0	9,879	0	0	0	0	0	0	0	0	0	9,879	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,404)</b>	<b>10,101</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,697</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	1,128	0	0	0	0	0	0	0	0	0	1,128	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(486)	21,683	0	0	0	0	0	0	0	0	0	21,197	19
20	Fees, Subscriptions & Promotions	0	140	0	0	0	0	0	0	0	0	0	140	20
21	Clerical & General Office Expenses	(2,087)	37,247	0	0	0	0	0	0	0	0	0	35,160	21
22	Employee Benefits & Payroll Taxes	0	0	5,468	0	0	0	0	0	0	0	0	5,468	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	497	0	0	0	0	0	0	0	0	497	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(2,573)</b>	<b>60,198</b>	<b>5,965</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>63,590</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(4,977)</b>	<b>70,299</b>	<b>5,965</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>71,287</b>	<b>29</b>

## Summary B

Facility Name & ID Number	SCOTCHWOOD HEALTH CARE CENTER	#	0043661	Report Period Beginning:	1/1/2002	Ending:	12/31/2002
---------------------------	-------------------------------	---	---------	--------------------------	----------	---------	------------

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	1	Dietary	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100.00%	0		2
3	V	3	Housekeeping		Senior Living Properties, LLC	100.00%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100.00%	0		4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	222	222	5
6	V	6	Maintenance		Senior Living Properties, LLC	100.00%	9,879	9,879	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		8
9	V	10a	Therapy		Senior Living Properties, LLC	100.00%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100.00%	1,128	1,128	10
11	V	19	Professional Services		Senior Living Properties, LLC	100.00%	21,683	21,683	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	140	140	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	37,247	37,247	13
14	Total			\$			\$ 70,299	\$ *	70,299 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **SCOTCHWOOD HEALTH CARE CENTER**# **0043661**Report Period Beginning: **1/1/2002**Ending: **12/31/2002****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 Employee Benefits & Payroll Taxes	\$	Senior Living Properties, LLC	100.00%	\$ 5,468	\$ 5,468	15
16	V	24 Travel and Seminar		Senior Living Properties, LLC	100.00%	497	497	16
17	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	0		17
18	V	30 Depreciation		Senior Living Properties, LLC	100.00%	978	978	18
19	V	32 Interest		Senior Living Properties, LLC	100.00%	1,019	1,019	19
20	V	33 Real Estate Taxes		Senior Living Properties, LLC	100.00%	0		20
21	V	34 Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	2,767	2,767	21
22	V	35 Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	222	222	22
23	V	36 Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	154	154	23
24	V	0	0			0		24
25	V	0	0			0		25
26	V	0	0			0		26
27	V	0	0			0		27
28	V	0	0			0		28
29	V	0	0			0		29
30	V	0	0			0		30
31	V	0	0			0		31
32	V	0	0			0		32
33	V	0	0			0		33
34	V	0	0			0		34
35	V	0	0			0		35
36	V	0	0			0		36
37	V	0	0			0		37
38	V	0	0			0		38
39	Total		\$			\$ 11,105	\$ *	11,105 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER# 0043661Report Period Beginning: 1/1/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTE # 0043661 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Senior Living Properties, LLC

Street Address 12400 N. Meridian Street, Suite 180

City / State / Zip Code Carmel, Indiana 46032

Phone Number (317) 208-2740

Fax Number (317) 575-2562

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	See attachment	See attachment	See attachment	\$ 163	\$	See attachment	0	1
2	2 Food Purchase	See attachment	See attachment	See attachment	0		See attachment	0	2
3	3 Housekeeping	See attachment	See attachment	See attachment	0		See attachment	0	3
4	4 Laundry	See attachment	See attachment	See attachment	60		See attachment	0	4
5	5 Heat and Other Utilities	See attachment	See attachment	See attachment	18,884		See attachment	222	5
6	6 Maintenance	See attachment	See attachment	See attachment	741,985		See attachment	9,879	6
7	7 Waste Removal	See attachment	See attachment	See attachment	0		See attachment	0	7
8	10 Nursing & Medical Records	See attachment	See attachment	See attachment	300		See attachment	0	8
9	10a Therapy	See attachment	See attachment	See attachment	0		See attachment	0	9
10	17 Administrative	See attachment	See attachment	See attachment	84,798		See attachment	1,128	10
11	19 Professional Services	See attachment	See attachment	See attachment	1,775,423		See attachment	21,683	11
12	20 Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	76,549		See attachment	140	12
13	21 Clerical & General Office Expense	See attachment	See attachment	See attachment	3,248,251		See attachment	37,247	13
14	22 Employee Benefits & Payroll Tax	See attachment	See attachment	See attachment	228,203		See attachment	5,468	14
15	24 Travel and Seminar	See attachment	See attachment	See attachment	821,540		See attachment	497	15
16	26 Insurance - Prop Liab Malpractice	See attachment	See attachment	See attachment	0		See attachment	0	16
17	30 Depreciation	See attachment	See attachment	See attachment	73,575		See attachment	978	17
18	32 Interest	See attachment	See attachment	See attachment	145,409		See attachment	1,019	18
19	33 Real Estate Taxes	See attachment	See attachment	See attachment	16		See attachment	0	19
20	34 Rent-Facility & Grounds	See attachment	See attachment	See attachment	208,088		See attachment	2,767	20
21	35 Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	32,533		See attachment	222	21
22	36 Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	12,011		See attachment	154	22
23	0	0			0				23
24	0	0			0				24
25	TOTALS				\$ 7,467,788	\$		\$ 81,404	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER # 0043661 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	GMAC Comm Mort Corp		X	Acquisition	\$199,355.00	2/6/98	\$ 2,843,306	\$ 3,215,009	2/1/08	0.0681	\$ 223,779	1	
2	Complete Care Services		X	Acquisition	\$734.00	2/6/98	125,810	132,910	2/6/08	N/A - None	N/A - None	2	
3	Manager Note		X	Acquisition	\$734.00	2/6/98	125,810	132,910	2/6/08	N/A - None	N/A - None	3	
4												4	
5												5	
	Working Capital												
6	Line of Credit		X	Working Capital	None	2/6/98	Various		Demand	Prime + 2%	22,180	6	
7	Other Interest										36,478	7	
8												8	
9	TOTAL Facility Related				\$200,823.00		\$ 3,094,926	\$ 3,480,829				\$ 282,437	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 3,094,926	\$ 3,480,829				\$ 282,437	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ \_\_\_\_\_      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **SCOTCHWOOD HEALTH CARE CENTER**# **0043661** Report Period Beginning: **1/1/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ <b>21,413</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>21,413</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>21,413</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>21,413</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997 <b>10,001</b>	8	
	1998 <b>19,557</b>	9	
	1999 <b>19,794</b>	10	
	2000 <b>2,939</b>	11	
	2001 <b>21,413</b>	12	
		<b>FOR OHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    SCOTCHWOOD HEALTH CARE CENTER    COUNTY    MCLEAN

FACILITY IDPH LICENSE NUMBER    0043661

CONTACT PERSON REGARDING THIS REPORT    William H. Keys

TELEPHONE    (317) 208-2740    FAX #:    (317)581-9513

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?               YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 15,386

B. General Construction Type:
 Exterior
 BRICK
 Frame
 WOOD
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

---



---



---



---



---



---

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	66,211	1998	\$ 119,192	1
2					2
3	TOTALS	66,211		\$ 119,192	3

Facility Name &amp; ID Number SCOTCHWOOD HEALTH CARE CENTER

# 0043661

Report Period Beginning:

1/1/2002

Ending:

12/31/2002

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		1998	1972	\$ 709,976	\$ 23,666	30	\$ 23,666		\$ 116,357	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	install alarm		1998		619	62	10	62		268	9
10	vinyl handrail		1998		698	47	15	47		191	10
11	replace tiles		1998		1,306	65	20	65		282	11
12	shower wall		1998		1,435	72	20	72		329	12
13	alarm system		1998		2,075	208	10	208		900	13
14	signage		1998		464	46	10	46		212	14
15	land improvements (purchases price)		1998		49,736	3,316	15	3,316		16,303	15
16	fire sprinkler repair		1999		3,585	359	10	359		1,405	16
17	painting		1999		2,832	566	5	566		2,123	17
18	circuits		1999		2,677	134	20	134		424	18
19	install chain link fence		1999		2,795	186	15	186		714	19
20	chain link fence		1999		2,795	186	15	186		620	20
21	watchmate security system		1999		6,892	689	10	689		2,354	21
22	security transmitter		1999		749	75	10	75		256	22
23	painting hallways		1999		2,832	566	5	566		1,934	23
24	window tinting		1999		1,432	143	10	143		453	24
25	floor base		2000		572	38	15	38		130	25
26	heating system repair		2000		3,960	264	15	264		616	26
27	water heater		2000		1,710	171	10	171		399	27
28	hot water heater				901	90	10	90		195	28
29	land improvements (purchases price)		1998		(49,736)	(3,316)	15	(3,316)		(16,303)	29
30	modifications to doors		2002		717	9	7	9		9	30
31	security system update		2002		1,933		7				31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 752,955	\$ 27,642		\$ 27,642	\$	\$ 130,171	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 135,582	\$ 18,519	\$ 18,519	\$	Various	\$ 81,259	71
72	Current Year Purchases	4,192	375	375		Various	375	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 139,774	\$ 18,894	\$ 18,894	\$		\$ 81,634	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,011,921	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,536	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,536	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 211,805	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<b>N/A</b>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: **N/A** \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **51,495** Description: **Central Supply - 49,629, Dietary - 588, Plant - 578, Laundry - 167, Administrative - 311, Home Office - 222**

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<b>N/A</b>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2003** \$

13. **/2004** \$

14. **/2005** \$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	652	\$ 45,263	\$ 129	652	\$ 45,392	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		59	7,613	0	59	7,613	2
3	Licensed Recreational Therapist	10a, 3	hrs		0	0	12,499		12,499	3
4	Licensed Physical Therapist	10a, 3	hrs		839	54,165	413	839	54,578	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	1,550	\$ 107,041	\$ 13,041	1,550	\$ 120,082	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 40,989	\$	1
2	Cash-Patient Deposits	1,813		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	332,232		3
4	Supply Inventory (priced at )	12,712		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 387,746	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	119,192		13
14	Buildings, at Historical Cost	756,048		14
15	Leasehold Improvements, at Historical Cost	55,790		15
16	Equipment, at Historical Cost	130,627		16
17	Accumulated Depreciation (book methods)	(228,108)		17
18	Deferred Charges	1,588,095		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(469,968)		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,951,676	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,339,422	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 191,877	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,518		28
29	Short-Term Notes Payable	750,694		29
30	Accrued Salaries Payable	65,724		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,522		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Other accrued expenses	12,158		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,078,493	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,410,157		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,410,157	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,488,650	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,149,228)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,339,422	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (1,425,648)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Restatements of Prior Year to allow rollforward</b>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (1,425,648)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(730,944)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>PRIOR YR ADJ - DEPREC</b>	<b>7,364</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (723,580)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (2,149,228)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,070,807	1
2	Discounts and Allowances for all Levels	(449,328)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,621,479	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	200,589	6
7	Oxygen	27,647	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 228,236	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	315	13
14	Non-Patient Meals	2,237	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	41,721	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,959	19
20	Radiology and X-Ray		20
21	Other Medical Services	127,005	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 173,237	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 20	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,022,972	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	464,835	31
32	Health Care	1,218,536	32
33	General Administration	591,017	33
	<b>B. Capital Expense</b>		
34	Ownership	411,623	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	25,200	35
36	Provider Participation Fee	42,705	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,753,916	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(730,944)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (730,944)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **SCOTCHWOOD HEALTH CARE CENTER**

# 0043661

Report Period Beginning: 1/1/2002

Ending:

12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,725	2,907	\$ 71,103	\$ 24.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,703	7,549	135,314	17.92	3
4	Licensed Practical Nurses	10,800	11,449	201,281	17.58	4
5	Nurse Aides & Orderlies	36,498	39,429	441,140	11.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,449	1,495	16,295	10.90	8
9	Activity Director	2,057	2,167	25,915	11.96	9
10	Activity Assistants	2,043	2,189	24,178	11.05	10
11	Social Service Workers	3,628	3,884	52,141	13.42	11
12	Dietician	1,816	2,041	25,945	12.71	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,147	10,759	96,938	9.01	15
16	Dishwashers					16
17	Maintenance Workers	2,511	2,656	33,475	12.60	17
18	Housekeepers	8,430	9,069	75,875	8.37	18
19	Laundry	2,615	2,659	23,203	8.73	19
20	Administrator	1,901	2,046	64,023	31.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,932	5,406	67,231	12.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,327	1,457	23,182	15.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,582	107,162	\$ 1,377,239 *	\$ 12.85	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	146	\$ 5,830	1, 3	35
36	Medical Director		8,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		30	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	2,952	11, 3	44
45	Social Service Consultant	51	2,952	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	250	\$ 20,164		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	336	\$ 16,199	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	336	\$ 16,199		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
June George	Admin.	0	\$ 64,023	Workers' Compensation Insurance	\$ 43,722	IDPH License Fee	\$				
				Unemployment Compensation Insurance	(3,411)	Advertising: Employee Recruitment	14,656				
				FICA Taxes	121,200	Health Care Worker Background Check					
				Employee Health Insurance	41,051	(Indicate # of checks performed 12 )					
				Employee Meals	0						
				Illinois Municipal Retirement Fund (IMRF)*	0	Dues & Subscriptions	2,154				
					0	Advertising & Public Relations					
					0						
					0						
					0						
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 64,023								
B. Administrative - Other				Home Office Allocation							
					5,468						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,733	TOTAL (agree to Schedule V, line 22, col.8)		\$ 208,030	TOTAL (agree to Sch. V, line 20, col. 8)				
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
Legal Fees	Various		\$ 486	N/A		\$	Out-of-State Travel	\$			
Patient Litigation	Various										
Payroll Processing	Various										
Accounting	Various		6,500				In-State Travel	10,341			
EDP Services	Various		4,498								

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

[illegible]

Facility Name & ID Number SCOTCHWOOD HEALTH CARE CENTER

STATE OF ILLINOIS

# 0043661

Report Period Beginning:

1/1/2002

Ending:

Page 23

12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,198 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 42,705  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,237
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.